Submission of this completed form or submission of the same information in a different format by the due date satisfies the requirement under HFS 68.05 for a distinct program budget for the AFCSP.

Wisconsin Department of Health and Family Services
Division of Disability and Elder Services
Bureau of Aging and Disability Resources

_____
(County)

ALZHEIMER'S FAMILY AND CAREGIVER SUPPORT PROGRAM BUDGET REPORT

for
2006

County designated AFCSP lead agency: _____

1. 2006 allocation: $_____

2. Number of households to be enrolled and served in coming year: _____

3. Planned distribution of funds by purpose, in % and dollars (HSS 68.06):

___ % a. Goods and Services $_____

___ % b. Contracts for development of new or expanded services (complete item #7) $_____

___ % c. Outreach activities and public awareness $_____

___ % d. Support group development or assistance $_____

___ % e. Program Administration $_____

4. Check all applicable planned method(s) for distribution of funds (HSS 68.09):

___ a. Payment to service provider for direct care.

___ b. Payment to service provider for development or expansion of services. (complete item #7)

___ c. Payment to household of person with Alzheimer's disease (i.e., cash grant for agreed upon services/goods).

___ d. Payment to manager of a residential facility for services to residents with Alzheimer's disease enrolled in AFCSP.

5. Indicate the maximum amount payable in the calendar year to or on behalf of any participating person:

___ $4,000

___ If less than $4,000, indicate amount of maximum. $

6. Briefly describe any limitations on goods and services that are to be provided, purchased, or contracted for (e.g., "will fund only respite care" or "adult day care will be funded only at XYZ Center"). See HSS 68.06(2)(b) for list of all possible services. If no limitations, indicate none.

7. Briefly describe if new programs or expanded services are planned for the coming year. [See definitions under HSS 68.02 (8) and (13)]. Please indicate if this is year 1, 2, 3 of the program development or expansion.

8. Summarize your waiting list policy, or attach a copy if changed during the past year.

9. Name and telephone number of contact person(s):

Program Contact: _____
(Name) (Phone)

Mailing Address: _____

_____

E-mail address: _____

Fiscal Contact, if different: _____
(Name) (Phone)
Fiscal Contact E-mail address: _____

Person Completing Form: _____
(Signature) (Phone)
Office FAX number _____

PLEASE MAIL COPY TO:

1) ATTN: Florence Rosner
Wisconsin Department of Health and Family Services
Division of Disability and Elder Services
Bureau of Aging and Disability Resources, Room 450
P.O. Box 7851
Madison, WI 53707-7851
E-mail address: rosnefp@dhfs.state.wi.us
Fax #: 608-267-3203

And to

2) *Your OSF Regional Office* ***or*** *Area Agency on Aging*